

CORRECTIONAL HEALTH CARE: IMPLICATIONS FOR PUBLIC HEALTH POLICY

Diane L. Adams, MD, MPH, and Brenda A. Leath, MHSA
Washington, D.C.

"Correctional Health Care: Implications for Public Health Policy" is the first in a series of articles that examines the special health care needs of persons who are incarcerated in America's correctional facilities. The intent of the series is to gain a better understanding about the unmet health needs of incarcerated persons, the importance of addressing the health service delivery system in correctional facilities, and the implications that may arise from neglecting to address these health issues on health outcomes for individual detainees and society at-large when detainees transition back into the community.

This article provides a descriptive overview of the corrections population, their socio-demographics, health care needs, and health concerns that are in need of improvement. This article also offers recommendations for public policy consideration to improve the overall health of inmates and society at large.

OVERVIEW OF THE CORRECTIONS POPULATION

As recently as March 2001, the growth of the prison population in the U.S. captured the attention of numerous news reporters. According to Randall, "...the number of inmates in the nation's prisons and jails reached nearly 1,932,000, a record number. While the U.S. accounts for just 5% of the global population, 25% of the world's prisoners are in American prisons and jails....Included among these prisoners are also more than 3,600 death row inmates..." (Randall, 2001).

Factors contributing to the growth of the incarcerated population are attributed to stiffer sentencing laws in general, as well as laws associated with drug-related offenses. The socio-demographic characteristics of those who are incarcerated tends to be "...overwhelmingly the working class

and poor and disproportionately minority... Racial minorities account for nearly 80% of all state drug offenders, many of whom end up as prison inmates...Black males are imprisoned in record numbers in the U.S. and on any given day, nearly one in eight black males aged 20 to 34 are in jail or prison..." (Randall, 2001).

Schrieber states, "... The prison population is growing at a record pace—over 7% annually—but for the first time, it's graying even faster. The U.S. Department of Justice estimates that by the end of next year the U.S. prison population will exceed 2 million. And like society at large, prisoners are getting older, sicker, and more costly to care for..." Reports indicate that the United States now surpasses Russia and takes second place in the world behind Rwanda in incarcerations (Eisner, 2001). Sentencing laws targeting

juvenile offenders has influenced the rise in the number of young persons in correctional facilities with a growing number being housed in adult facilities.

Now laws such as the Truth-in-Sentencing law, which requires violent offenders to serve 85% and non-violent offenders to serve 50% of their sentence before being considered for parole, is giving rise to the growing population of inmates who are over age 50. According to Mayko, "...the analysts predict the number of inmates over age 50 will reach 225,000 in the next six years..." (Mayko, 1999).

Major Health Concerns

An unhealthy aging prison population, a high incidence and prevalence of infectious and communicable diseases, limited health literacy among the inmate population, and substandard care are among the health care challenges facing prison facilities today.

In his article, "Is Prison Health Care Ailing?" Shapinsky cites Corrections Official Thomas Conklin, who says, "...improving prisoners' health care will pay off for society in lots of ways. Conklin argues that prisons and jails are early "warning centers"—places where public health problems can be detected and addressed before they spin out of control. He points out that the average prison stay is 52 days; short-term inmates return to the community as neighbors, fellow workers and family members." (Shapinsky, 1999). In such instances, when the inmates' health conditions were not addressed during incarceration, the revolving door effect of spreading disease both inside the prison walls and outside upon return to the community can occur. This is particularly true, if the health problem is of an infectious or communicable origin.

Nicodemus and Paris report some rather startling health statistics about prisoner health, which were based on the National Commission on Correctional Healthcare's Health Status of the Soon-to-be-Released Inmates project.

"...Diseases which are most prevalent in prisons are HBV and HCV, HIV, sexually transmitted diseases (STDs), including syphilis, chlamydia and gonorrhea, and airborne diseases such as TB [tuberculosis]..."

◆ 98,000 to 148,000 soon-to-be-released inmates were infected with HIV at the time the study was carried out (1998). This number represents 12 to 18% of the total infected population in the U.S.

◆ In 1999 it was estimated that 558,000 inmates were infected with syphilis (RPR+) compared to 186,000 inmates infected with chlamydia and 77,500 inmates infected with gonorrhea.

◆ Active TB was detected in 12,000 U.S. inmates in 1999, which accounts for 35% of total cases of TB disease in the U.S.

◆ In 1999 it was estimated that 155,000 inmates being released were found to be infected with HBV and up to 1.25 million inmates being released were found to be infected with HCV...."

Due to variances in the use of standards of care, disparities exist in the rates of diseases for the incarcerated vs. the general population. Hammett, et al. indicate that "...among the incarcerated, rates of HIV are 8 to 10 times higher, rates of hepatitis C are 9 to 10 times higher and rates of TB are 4 to 17 times higher than rates for the general public..." (Hammett, et al., 1999). "...Most inmates with infectious diseases come to jail or prison already infected..." (Kendig, 1999). Sources indicate that, "...HIV infection among incarcerated women has become a hidden epidemic in the United States. Factors that contribute to this epidemic include the increase of over 500% in the absolute number of women incarcerated in 1999 compared to U.S. women in general (3.5% vs 0.1%) (Onorato, 2001 and U.S. Department of Health and Human Services Office of Minority Health, 2001). "...This high rate of HIV infection among incarcerated women is related to their lifestyles prior to incarceration, which often included violence, drug and/or alcohol abuse, promiscuity, and prostitution..." (Osemene et al., 2001).

Eisner reports that "... psychiatrist Terry Kupers, author of "Prison Madness—the Mental Health Crisis Behind Bars," estimates that 10 to 20% of inmates suffer from grave mental illness; AIDS, hepatitis and drug-resistant tuberculosis are rife and often go untreated... ." This is further substantiated by other reports of disablement among the incarcerated. According to Russell, "...the disabled are disproportionately represented among the prison population. While Census data suggest that disabled persons represent approximately one-fifth of the total population, prevalence of disability among prisoners is higher. Hearing loss, for example, is estimated to occur in 30% of the prison population, while estimates of the prevalence of mental retardation among prisoners range from 3 to 9.5%...."

In his article, "Coping with Mental Illness in Prisons," Lovell indicates that there are variances in the estimates of prisoners who are mentally ill, which is influenced by the way jurisdictions define mental illness and the assessment methods used to identify and measure the condition. However, Lovell offers an explanation about the significant numbers of persons who are mentally disabled and reside in prison. He states that, "...the prevalence of serious mental illness in prisons is partly attributable to our society's increasing proclivity for using prisons and jails to manage social ills and their attendant misery..." (Lovell, 1998). Such patterns suggest a need to revisit and develop new strategies for eliminating access barriers to community-based systems for the delivery of mental health care.

The aging prison population presents numerous challenges for facilities. Not only are they more expensive to care for, "...but because age-related health problems usually occur earlier in life for prisoners, inmates are considered elderly at age 55..." (Schrieber, 1999). This translates into a premature aging process at a rate that is ten years earlier than their non-incarcerated counterparts. According to prison expert Norman Cox, "we anticipate a 50 to 70% increase in their numbers [persons over 50] over the next five years" (Mayko, 1999).

Factors Influencing Health Outcomes for Inmates

Risky behaviors and denied access to treatment are two factors that influence negative health outcomes for inmates. Intravenous drug use, unprotected sex, and tattooing are examples of risk behaviors that occur. While "...laws governing prison conduct can be barriers to disease prevention; sexual activity (including consensual sex, rape, gang rape and survival sex), drug use, and tattooing are illegal in prisons and jails; nevertheless, these activities occur..." (Zack, et al., 2000).

A report indicates, "...in prisons and jails across the country, inmates with HIV or AIDS are being denied proper treatment. In many cases, guards and medical staff have blocked inmates from getting their vital drug regimens, sometimes for months at a time, or have prescribed regimens that are dangerous. Such negligence can lead to drug resistance. It can also lead to death... Similar findings were substantiated by Christine Doyle, research coordinator for Amnesty International, USA, who states, "...We routinely get letters from people who are not getting their medications..." (Cusac, 2000).

Another account of denied access to appropriate health care is highlighted by Robert Cohen, MD, a physician in New York who has an extensive background in prison health care. He filed a "Report on the Medical Care of Prisoners with HIV Infection at the Mississippi State Prison Parchman Farm," dated Feb. 25, 1999. "There is a policy at Parchman, clearly stated within the medical records, that patients cannot receive [the protease inhibitor] Crixivan until they have received two medications alone for six months," he wrote. "Adding one new drug to a failing two-drug regimen assures the early development of resistance. This is almost always the wrong approach, and it is the only approach taken at MSP/Parchman..." (Cusac, 2000).

"While the incarcerated are the only population in the U.S. that has a constitutional right to health care" [Zack, et al., 2000] "...security is a primary concern and may complicate treatment

of inmates. Elderly prisoners with health care needs often find themselves in facilities that are ill-equipped to address the needs of the aged, especially those which have been neglected for many years..." (Schrieber, 1999).

Implications for Needed Improvements in Service Delivery

Several factors point to the need for improvements in correctional health care. A few examples are highlighted below, and if not given consideration, could have profound implications on the health and well being of prisoners, as well as those persons who supervise and treat inmates within the correctional system. Such implications can extend beyond the prison walls to the community, where, upon release, the individual lives (e.g., family). Examples of such factors that need to be addressed are:

- ◆ Revolving door patterns of some prisoners who find it difficult to successfully transition back into the community and lead productive lives. Many times inmates re-enter the correctional system with the same neglected health condition as when they were released.

- ◆ Limited monitoring and surveillance of infectious and communicable diseases. Without proper monitoring and surveillance of infectious and communicable diseases within the correctional setting, the population at risk expands beyond the individual inmate to everyone who comes in contact with that person, including staff and visitors.

- ◆ Limited formal health education activities. Peer education/mentoring programs are often effective measures that can be used by inmates to help each other better understand the risks and consequences of various health conditions if preventive measures are not taken.

- ◆ Inconsistent and proactive prevention and treatment measures to protect inmates, staff, and visitors from contracting infectious and communicable diseases. If such conditions as hepatitis (HAV, HBV and HCV), HIV/AIDS or TB, to name a few, continue to go unnoticed, then this may lead to an epidemic or public health crisis.

- ◆ Significant numbers of incarcerated per-

sons with mental health needs. Access to psychosocial services should be provided to inmates with mental illness upon entering, during the period of incarceration and upon release.

- ◆ Lack of attention towards reducing stigma and discrimination associated with certain diseases. The stigma and discrimination associated with various health conditions should be addressed to encourage proactive healthcare-seeking behaviors among inmates.

- ◆ Manual record-keeping is still being utilized in many correctional facilities suggesting the need to develop more sophisticated infrastructure for data systems that take into consideration privacy and confidentiality.

CONCLUSION

Evidence from various studies and statistical profiles clearly indicate a need to address health issues in correctional facilities throughout the United States. Ignoring the health and well being of the incarcerated not only places them at risk for illness, disability, and death, but also increases the risks of others with whom they come in contact. Improvements needed within the correctional system include but are not limited to those at the facility-level such as congruent facility and medical policies and procedures, current treatment protocols, current patient information systems, and safe environmental conditions through federal regulations and policies that mandate access to quality services.

Such improvements can best occur through collaborative activities involving multidisciplinary partners such as Members of Congress, state legislators, local policymakers, correctional officials, health departments, law enforcement, physicians and other health care providers, community leaders, advocates, and a host of other stakeholders who are committed to the public's overall health and safety. The recommendations that follow are the initial steps that need to be taken to accomplish a more humane system of health care for inmates.

Recommendations for Public Health Policy

1) Develop and enforce regulations to ensure compliance with federal mandates for inmate access to quality health care as a matter of constitutional rights.

2) Assure inmate access to primary health, mental health, and dental services that are age- and gender-appropriate as part of a basic and general health regimen for prison health care.

3) Mandate the conduct of a national study to assess levels of disparities in health service access and delivery to all correctional facilities in the United States.

4) Federally mandate that all U.S. correctional facility policies be reviewed and evaluated to determine whether any existing policies are in conflict with recommended medical treatment protocols.

5) Mandate that facility policies are compatible with and promote clinician adherence to appropriate standards of care and that the standards of care are based on clinical guidelines and protocols used in other segments of the population with the same or similar health conditions.

6) Institutionalize preventive health policies and procedures that incorporate routine screening at the points of entry, periodically during incarceration, and upon exiting the correctional system to facilitate early diagnosis and treatment of infectious and communicable diseases.

7) Mandate the implementation of comprehensive infection control measures that not only address the health risks of inmates, but also provide health protections for correctional staff, medical staff, and visitors for all federal, state, and local correctional facilities.

8) Institutionalize total quality management programming at all correctional facilities to monitor and document adherence and compliance with established standards of care.

ABOUT THE AUTHORS

Diane L. Adams, MD, MPH, is the director of Health Policy, Research, and Professional Medical Affairs at the National Medical Association.

Brenda A. Leath, MHSA, is the president and chief executive officer of the National Consortium for African American Children.

REFERENCES

1. Bick J, ed., "Tuberculosis in Corrections: 2002 Update," *HEPP News*. Brown Medical School HIV & Hepatitis Education Prison Project, March 2002.
2. Cusac A, "The Judge Gave Me Ten Years. He Didn't Sentence Me to Death." Inmates with HIV or AIDS, *US Progressive*. July 2000; p. 1-10.
3. Eisner A, "Huge US Prison Population Social Cost," *US Wire*, January 23, 2001.
4. Hammett TM, Harmon P, Maruschak L. 1996-1997 Update: HIV/AIDS, STDs and TB in Correctional Facilities. Abt Associates Inc.: Cambridge, MA; 1999.
5. Kendig NE. "The State of Correctional Health Care At the End of the Millenium." Presented at the National Conference on Correctional Health Care. Ft. Lauderdale, FL. November, 1999.
6. Lovell D, "Coping with Mental Illness in Prisons." *Family and Community Health*. October 1998, p. 1-14.
7. Maue FR, Arrow, DO, Strine M. "Hepatitis A & B Vaccination Program for Inmates and Staff." The Corrections Connection Health Care Network Website, www.corrections.com, 2002.
8. Mayko MP, "Corrections Looking Into Health Needs of Elderly Patients." *The News-Times Regional News*, www.newstimes.com. September 17, 1999.
9. Nicodemus M, Paris J. "Bridging the Communicable Disease Gap: Identifying, Treating, and Counseling High-Risk Inmates." *HEPP News*. Brown Medical School HIV & Hepatitis Education Prison Project, vol. 4, issues 8,9; August/September, 2001.
10. Office of Minority Health US Department of Health and Human Services. *Closing the Gap Newsletter*. December, 2001.
11. Onorato M, "HIV Infection Among Incarcerated Women." *HEPP News*. Brown Medical School HIV & Hepatitis Education Prison Project, vol. 4, issue 5; May 2001.
12. Osemene NI, Essien EJ, Egbunike IG. "HIV/AIDS Behind Bars: An Avenue for Culturally Sensitive Interventions." *JNMA*. vol.93, no.12; December 2001.
13. Randall K, "US Prison Population to Reach A Record Two Million By Year's End." *World Socialist Website*, www.wsws.org, March 28, 2001.
14. Russell M. "Disablement, Prison and Historical Segregation." *Monthly Review*. July 2001, p. 1-13.
15. Schreiber C. "Behind Bars: Aging Prison Population Challenges Correctional Health Systems." *Nurse Week*, www.nurseweek.com. July 19, 1999.
16. Shapinsky D, "Is Prison Health Care Ailing? Critics Say Poor Care Creates Public Health Threat," www.ABCNEWS.com. November 5, 1999.
17. Zack B, Flanigan T, Decarlo P. "What Is The Role Of Prisons In HIV, Hepatitis, STD, and TB Prevention?" Fact Sheet #13ER, Center for AIDS Prevention Studies, University of California San Francisco, AIDS Research Institute, August 2000.